

FILED OCT 10 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32095

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>3069</u>		Registrar's No. <u>2358</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Macoupin</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>		c. LENGTH OF STAY (In this place) .....		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carlinville</u>		<u>8120</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>8</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Daniel</u>		b. (Middle) <u>E.</u>		c. (Last) <u>Sexton</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 30 1950</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>June 8, 1872</u>	
9. AGE (In years last birthday) <u>78</u>		10. UNDER 1 YEAR Months Days		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Postmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY .....		13a. FATHER'S NAME <u>Jeremiah Sexton</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Magda lene Sexton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Dr. Daniel Sexton 14 Crestwood Drive</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Colon with metastases - Right colon</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ..... DUE TO (c) ..... II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of rectum 153X</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Extensive recurrence in ascending colon and nodes.</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>153X</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) .....		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) .....		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) .....		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>3-28, 1949</u> , to <u>9-30, 1950</u> , that I last saw the deceased alive on <u>9-30, 1950</u> and that death occurred at <u>3:45 pm.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Charles H. Herndon</u>		23b. ADDRESS <u>3120 Washington St. St. Louis Mo.</u>		23c. DATE SIGNED <u>10-2-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>10-1-1950</u>		24c. NAME OF CEMETERY OR CREMATORY .....		24d. LOCATION (City, town, or county) (State) <u>Carlinville, Illinois</u>	
DATE REC'D BY LOCAL REG. <u>10-2-50</u>		REGISTRAR'S SIGNATURE <u>J. R. Donke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

working under my personal supervision.

Student Embalmer No. ....

Signed

*Wm S. Saffin*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address St Charles

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.